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Attorney for Plaintiffs

**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MONTANA
HELENA DIVISION**

Dale Fossen, et al.,)
)
) **Cause No.: CV 09-61-H-CCL**
Plaintiffs,)
)
)
-v-)
) **AFFIDAVIT OF**
)
) **DALE FOSSEN**
Blue Cross Blue Shield of)
Montana, Inc.,)
)
Defendant.)

1. My name is Dale Fossen, and I live at Fossen Brothers Farms,
305 3rd St. W., P.O. Box 102, Joplin, MT 59531.

2. During all times relevant hereto, Fossen Brothers Farms was a
partnership, consisting of farm corporations incorporated in Montana and
respectively entitled D and M Fossen, Inc., L and C Fossen, Inc., and M and C
Fossen, Inc. Brothers Dale Fossen, Larry Fossen, and Marlowe Fossen are the
presidents of each these respective corporations (hereinafter collectively referred to
as "Fossen Brothers").

3. Fossen Brothers Farms, the Fossen brothers, and their corporations reside in and farm in both Hill and Liberty Counties in the state of Montana.

4. In December 2003 and January 2004, Roger Olson of the Olson Insurance Agency of Chester, Montana, on behalf of Blue Cross Blue Shield of Montana offered to enroll the Fossen Brothers in what he characterized as a "true pool risk plan" offered by Associated Merchandisers, Inc. (AMI). He informed us that we would be rated once and only once for the plan and would not be rerated during our participation. He informed us that any increase in premiums would be a pool wide rate increase that everyone would share equally.

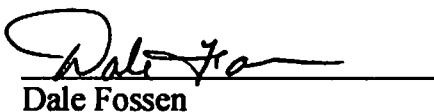
5. Mr. Olson gave me an application form with a Blue Cross Blue Shield logo and the heading "ASSOCIATED MERCHANDISERS, INC. (AMI) GROUP HEALTH BENEFITS PLAN EMPLOYER ELECTION FORM." I filled out this form, a copy of which is attached to this affidavit as Exhibit 1. From the heading on the application, as well as from Mr. Olson's explanation, I believed that the "group" or risk-sharing pool into which we were buying consisted of all the small businesses subscribing to AMI. I believed that all these small businesses would be rated together, so that premium increases would be the same for all.

6. In or about April 2006, Blue Cross increased the Fossen Brothers' AMI premium by over 21%. The insurance agent, Roger Olson, told us that some members of the AMI group were incurring premium increases of 7%, 9%, and 24%, and some members were receiving decreases of up to 9%. I complained to

the Insurance Department of the Montana State Auditor's Office regarding this increase.

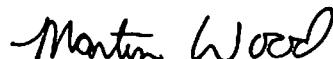
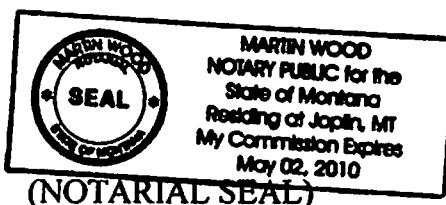
7. In 2009, Blue Cross Blue Shield changed the AMI Plan to the Montana Chamber Choices Plan. On behalf of Fossen Brothers, I filled out an application form entitled "MONTANA CHAMBER CHOICES ASSOCIATION 2009 GROUP HEALTH BENEFITS PLAN EMPLOYER ELECTION FORM." A copy of this application is attached to this affidavit as Exhibit 2.

Dated this 16 day of March 2010.



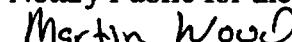
Dale Fossen

SUBSCRIBED AND SWORN TO before me this 16 day of March 2010.



Martin Wood

Notary Public for the State of Montana



Martin Wood

(Typed or printed name of Notary)

Residing in Joplin

My Commission Expires: May 2, 2010



An Incorporated Entity of the Blue Cross and Blue Shield Association

X 59184-207

ASSOCIATED MERCHANTISERS, INC. (AMI)
GROUP HEALTH BENEFITS PLAN EMPLOYER ELECTION FORM

Fossen Brothers Farms

Dale Fossen

Company Name

305 7th St. W.

P.O. Box 102

Group Contact Name

(406) 292-3250

Service Address

Joplin

Mailing Address

Telephone Number

59531

City

MT.

ZIP

1. Employer Tax Identification Number. If you have no TIN, Social Security Number	<u>31-093465</u>
2. For the current calendar year (January -Present), state the total number of employees* Have you had 20 or more employees during 20 or more work weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Do you expect to have 20 or more employees during at least 50% of your typical business days? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<u>3</u>
3. For the previous calendar year (January 1-December 31), state the total number of employees Did you have 20 or more employees during 20 or more work weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Did you have 20 or more employees during at least 50% of your typical business days? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<u>3</u>
4. Number of employees eligible for this benefit plan	<u>3</u> Employees

Answer the following questions for both Health and Life Benefit Plans

5. Group waiting period (probationary period)	<u>90</u> Days
6. Number of work hours per week required to be eligible for benefits	<u>32</u> Hours
7. Employer contribution (\$ or %) to premium	<u>100%</u> Employee <u>100%</u> Dependent
	<u>100%</u> Employee <u>100%</u> Dependent

Life
(optional)

90 Days

32 Hours

100% Employee

100% Dependent

***** BENEFIT OPTIONS *****

Medical Plan Options (Mandatory)	RATE LEVEL <u>Table 6</u>	Life Benefit
<input checked="" type="checkbox"/> Traditional Health First 50/50 \$500 Deductible		<input checked="" type="checkbox"/> Yes
<input type="checkbox"/> Traditional Health First 70/30 \$500 Deductible		<input type="checkbox"/> No
<input type="checkbox"/> PPO Health First 50/50 \$500 Deductible		
<input type="checkbox"/> PPO Health First 70/30 \$500 Deductible		
<input type="checkbox"/> Blue Saver 100/0 \$5,000 Deductible \$500 Primary Care Benefit		

Requested Effective Date 6-1-2004 I certify that all information provided by me to complete this application is true.

Dale Fossen

partner

Printed Name of Owner or Officer of the Group

Title

Dale Fossen

April 2, 2004

Signature of Owner or Officer of the Group

Date

Please Submit to Blue Cross and Blue Shield of Montana, P.O. Box 4309, Helena, MT 59604

RECEIVED
HELENA DISTRICT OFFICE

BLUE CROSS AND BLUE SHIELD
OF MONTANA

RECEIVED

APR 15 2004

APR 07 2004

APR 7 2004 ENROLLMENT TEAM

BLUE CROSS & BLUE SHIELD
OF MONTANA

APR 07 2004

MSS

EXHIBIT

1



MONTANA CHAMBER CHOICES ASSOCIATION
2009 GROUP HEALTH BENEFITS PLAN EMPLOYER ELECTION FORM

MCC SUBGROUP NO. 801Fosson Brothers Farms

Group Name

305 Third St. W.

Physical Address

 joyful, Mt. 59531

City

State

Zip Code

P.O. Box 102

Mailing Address

 joyful, Mt. 59531

City

State

Zip Code

MCC SUBGROUP NO. 801Dale Fosson

Group Contact Name

Telephone (406) 292-3230FAX (406) 292-3296

E-Mail Address

81-0595465

- Employer Tax Identification Number. If you have no TIN, Social Security Number: _____
- Coverage for Sole Proprietor/Owner-Operator? Yes No (If Yes, do not complete questions 3-6)
- For the current calendar year (January 1-Present), state the total number of employees: _____

Have you had 20 or more employees during 20 or more work weeks? Yes NoDo you expect to have 20 or more employees during at least 50% of your typical business days? Yes No

- For the previous calendar year (January 1-December 31), state the total number of employees: _____

Did you have 20 or more employees during 20 or more work weeks? Yes NoDid you have 20 or more employees during at least 50% of your typical business days? Yes No

- Current number of employees 3 Number of eligible employees 3 Number of enrolled employees 3
If your group is COBRA eligible, COBRA will be administered by BCBSMT.

- If COBRA eligible, number of COBRA participants enrolling 1/4

- Group waiting period (probationary period): (Must not exceed 30 days)
apply to health, vision, dental and life plan

- Number of work hours per week required to be eligible for benefits: _____

- Employer contribution to premium (% or \$): (Must be at least 50% for employee.)
100 % or \$ _____ Employee
100 % or \$ _____ Dependent

Please review definitions on reverse.

BENEFIT OPTIONS

Health First HealthLink
 \$300 Deductible 60/40
 \$300 Deductible 70/30
 \$1000 Deductible 30/30
 \$1500 Deductible 80/20

Big Sky Select 50/50; \$25 Office Visit 60/40; \$15 Office Visit

CMH 70/30 HealthLink \$200 Deductible

CMH 50/50 HealthLink \$200 Deductible \$1,000 Deductible

CMH-HSA Big Sky HealthLink
 \$2500 Deductible; 100/0 \$5000 Deductible; 100/0

\$3000 Life and \$3000 Accidental Death & Dismemberment Benefit
(Included with all Medical Options)

Dental Plan

\$25 Deductible
(Includes Orthodontics)

\$50 Deductible

 NO

Vision Plan

Yes

 NO

Helena District Office

MAY 06 2009

Effective Date: Renewed6/1/2009Rate Level: 9

I certify that all information provided by me to complete this application is true.

RECEIVED

Dale Fosson
Printed Name of Group LeaderGeneral Partner
TitleDale Fosson
Signature4-29-09
Date

Renewed
Renewal Date: 4-29-09
Representative Name: TEAM